

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10713

CERTIFICATE OF DEATH

10706

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 120 W. Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Memorial Hospital		d. STREET ADDRESS Hagerstown, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MAYME Middle G. Last BATTLE		4. DATE OF DEATH Month September Day 14 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 21, 1880
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) type of Work Unknown	11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Michael Battle		14. MOTHER'S MAIDEN NAME Honore Barrett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-10-3211	
17. INFORMANT Miss. Virginia Wills		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Auricular Fibrillation - Myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-Sclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1945 to 14 Sept 1961 , that (I) (we) last saw the deceased alive on 13 Sept 1961 , and that death occurred at 7:10 AM , from the causes and on the date stated above.			
22a. SIGNATURE F F Lusby		22b. DATE SIGNED 14 Sept 61	
22c. PHYSICIAN'S NAME (Type) F F Lusby		22d. ADDRESS 230 N Potomac St Hagerstown, Md	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 9/16/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Romzer Funeral Home A Franklin Boyer		25a. REC'D BY REGISTRAR DATE SEP 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10714

10707

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in 1b 7 1/2 weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Md. b. COUNTY Wash c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown d. STREET ADDRESS RFD 6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First Middle Last Charles Edward Beall				4. DATE OF DEATH Month Day Year Sept. 30, 19 61					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1908		9. AGE (In years last birthday) 52 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sheetmetal worker				10b. KIND OF BUSINESS OR INDUSTRY aircraft ind.		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Beall				14. MOTHER'S MAIDEN NAME Alice Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 214-16-0471		17. INFORMANT Address mrs. Arena Beall, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 20000 Reticulum cell sarcoma DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH June 9 - 1961	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from June 9, 1961 to Sept 30, 1961 that (I) (we) last saw the deceased alive on Sept. 30, 1961 and that death occurred 10:20 PM from the causes and on the date stated above.									
22a. SIGNATURE Sidney Novakstein M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10-3-61 22c. PHYSICIAN'S NAME (Type) SIDNEY NOVAKSTEIN 22d. ADDRESS Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 10-3-61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.						25a. REC'D BY REGISTRAR OCT 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed. Pages 3 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



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Washington County Hospital

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Arrival

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Washington County Hospital

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Charles

Edward

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Sept. 20

white

Nov. 21, 1908

abandoned worker direct ind. Frederick Co., Md.

George W. Hall

Allice Smith

no

211-10-0471 Mrs. Anna Hall, Washington, Md.

Peterson with Anderson

*Box 20 G
Ferry Mountain
21st Nov 1908
Washington Md*

Postal 12-1-01 Post Office Cemetery Washington, Md.

Scott T. Minnich & Son, Washington, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10715

CERTIFICATE OF DEATH

10708

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural 1		c. LENGTH OF STAY IN 1b 7 Months	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home		d. STREET ADDRESS Rural 1 Hancock Md.	
3. NAME OF DECEASED (Type or print) First Essie Middle Louise Last Berry		4. DATE OF DEATH Month 9 Day 1 Year 19 61	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1.29.61
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months 7 Days 2 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Morgan County W.VA.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C Berry		14. MOTHER'S MAIDEN NAME Violet M Knapp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Violet M Berry Rural 1 Hancock Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Virus Pneumonia 293X DUE TO (b) Anemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept 1 61 to Sept 1 61 , that (I) last saw the deceased alive on Sept 1 61 , and that death occurred at 2:15 PM from the causes and on the date stated above. 22a. SIGNATURE L M Shaffer M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) L M SHAFER 22d. ADDRESS Hancock, Md 22b. DATE SIGNED 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9.4.61 23c. NAME OF CEMETERY OR CREMATORY Fairview Christian 23d. LOCATION (City, town or county) (State) Artamus Bedford Penna. 24 FUNERAL DIRECTOR'S SIGNATURE Howard F. Stone ADDRESS Hancock Md 25a. REC'D BY REGISTRAR SEP 6 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Stone			

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10716

CERTIFICATE OF DEATH

Reg. Dist. No. 10709

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN 03</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WASHINGTON CO. HOSPITAL</u>				d. STREET ADDRESS <u>817 LANVALE ST.</u>			
3. NAME OF DECEASED (Type or print) <u>S HERRY</u> First <u>LYNN</u> Middle <u>BILLMAN</u> Last				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>F-M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 4, 1961</u>		9. AGE (In years last birthday) yrs. <u>11</u>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN MCCELLAND BILLMAN</u>				14. MOTHER'S MAIDEN NAME <u>PEGGY ANN MEYERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN MCCELLAND</u> Address <u>817 LANVALE ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Granulocytic Inflammation of Liver exact</u> <u>583X</u> DUE TO <u>Cause not known</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cause not known</u> DUE TO (c) <u>Cause not known</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atelactasis - Primary - Bilateral</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 4</u> , 19 <u>61</u> , to <u>15 Sept</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>15 Sept</u> , 19 <u>61</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N Potomac St Hagerstown MD</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				DATE SIGNED <u>16 Sept 61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>SEPT. 16, 1961</u>		<u>ROSE HILL CEMETERY</u>		<u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. T. Hagerman Hagerstown Md</u>				24a. REG'D BY REGISTRAR <u>SEP 20 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

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CERTIFICATE OF DEATH

10716

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<p>1. NAME OF DECEASED JAMES J. JONES</p>		<p>2. SEX M</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 12-15-1900</p>	
<p>5. PLACE OF BIRTH NEW YORK</p>		<p>6. OCCUPATION LABORER</p>	
<p>7. CAUSE OF DEATH HEART DISEASE</p>		<p>8. MANNER OF DEATH NATURAL</p>	
<p>9. DATE OF DEATH 12-25-1945</p>		<p>10. TIME OF DEATH 10:00 P.M.</p>	
<p>11. PLACE OF DEATH HOME</p>		<p>12. SIGNATURE OF PHYSICIAN J. J. JONES</p>	
<p>13. SIGNATURE OF REGISTRAR J. J. JONES</p>		<p>14. SIGNATURE OF CLERK J. J. JONES</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed, within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. B. B. KNEISLEY
148 W. WASH. ST.
HAGERSTOWN, MD.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10717						10710					
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>5 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>789 S. POTOMAC ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>WILLIAM REICHARD BOWERS</u>						4. DATE OF DEATH <u>SEPTEMBER 2, 1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DECEMBER 27, 1895</u>		9. AGE (In years last birthday) <u>65 yrs.</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED DRAFTSMAN POTOMAC EDISON CO.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>POTOMAC EDISON CO.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DOWNSVILLE WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM H. BOWERS</u>						14. MOTHER'S MAIDEN NAME <u>LUTIE COLBERT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>						16. SOCIAL SECURITY NO. <u>214-10-4212</u>					
17. INFORMANT <u>MRS. FRANK E. ALLEN</u>						Address <u>789 S. POTOMAC ST. HAGERSTOWN MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Chronic Endocarditis with Hypertension</u> DUE TO (c) <u>Vascular Disease & degenerative pathologic</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 28</u> 19 <u>61</u> , to <u>Sept 2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 1</u> 19 <u>61</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>B. B. KNEISLEY</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>B. B. KNEISLEY, MD.</u>						22d. ADDRESS <u>148 W. WASH. ST. HAGERSTOWN MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>SEPT. 4, 1961</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN WASH. CO. MD.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>						ADDRESS <u>BOONSBORO MD.</u>			25a. REC'D BY REGISTRAR <u>SEP 6 '61</u>		
									25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10718

CERTIFICATE OF DEATH

10711
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>3 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy BRAGUNIER</u>		4. DATE OF DEATH Month Day Year <u>SEPT 23 1961</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 23. 1961</u>
9. AGE (In years last birthday) <u>- yrs.</u>		10. IF UNDER 1 YEAR: Months Days Hours Min. <u>2 53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE C. BRAGUNIER</u>		14. MOTHER'S MAIDEN NAME <u>THELMA L. ROWLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT Address <u>Mrs. Thelma L. Bragunier (mother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT 23, 1961</u> to <u>SEPT 23, 1961</u> , that I last saw the deceased alive on <u>SEPT 23, 1961</u> , and that death occurred at <u>11:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>09/25/61</u> ACTUAL SIGNATURE <u>Archib Robert Cohen</u> M.D. PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN M.D. Clear Spring Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>19-27-61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hosp. Lab.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hume</u> ADDRESS <u>Clear Spring Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 1961</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

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may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.MARYLAND AND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) CLEAR SPRING		c. LENGTH OF STAY IN 1b LIFE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 112 MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 112 MAIN ST.							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES RICHARD BRENNAN		4. DATE OF DEATH Month Day Year SEPTEMBER 20 19 61									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 7, 1876		9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) INDIAN SPRINGS, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JAMES BRENNAN		14. MOTHER'S MAIDEN NAME MATILDA BOWMAN									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-28-1168		17. INFORMANT MRS GEORGIE BRENNAN		Address CLEAR SPRING, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA OF THE PROSTATE GLAND DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH 4 months unknown									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clear Spring, Maryland		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from May 29, 1961 , to Sept. 20, 19 61 , that (I) (we) last saw the deceased alive on September 19, 19 61 , and that death occurred at 1:55 PM , from the causes and on the date stated above.											
22a. SIGNATURE <i>Archie Robert Cohen</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 09/21/61							
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 27, 1961		23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town, or county) (State) WESTERN PIKE, ST. PAULS, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Margaret Rowland</i>		ADDRESS CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR DATE SEP 26 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

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RECEIVED
JAN 10 1964
U.S. AIR FORCE
OFFICE OF THE
JOINT CHIEFS OF STAFF
WASHINGTON, D.C.
20330-1000
ATTENTION: JCS
MEMORANDUM FOR THE
JOINT CHIEFS OF STAFF
SUBJECT: [Illegible]
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TO HO...
TO FUNERAL DIRECTOR:
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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10720						10713					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Q. Q.</u> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md. 020-2</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>50 Bloomsbury Sq.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>LEO P. BRIAND</u>						4. DATE OF DEATH <u>SEPT. 26 1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-17-1904</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Construction</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leo P. Briand</u>						14. MOTHER'S MAIDEN NAME <u>Mildred Brown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If give, give number and date of service)		17. INFORMANT <u>Lessie Briand</u> Address <u>(2)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> 463X DUE TO (b) <u>PHLEBOTROMBOSIS OF LEGS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>UNKNOWN</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMPHYSEMA - COR PULMONALE</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-6-</u> <u>1961</u> to <u>9-26</u> <u>1961</u> , that (I) (was) last saw the deceased alive on <u>9-26</u> <u>1961</u> , and that death occurred at <u>1226</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Antonio U. Pallagrosi</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>						22d. ADDRESS <u>1500 Pa AVE HAGERSTOWN MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9-29-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Annis Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis Md.</u>						25a. REC'D BY REGISTRAR <u>Oct 2 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

3170

1995



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 hours		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
3. NAME OF DECEASED (Type or print) First Frank Middle Euing Last Bushey, Sr.		4. DATE OF DEATH Month Sept. Day 26, Year 19 61		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1888	9. AGE (In years last birthday) 73 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) president		10b. KIND OF BUSINESS OR INDUSTRY lumber company		11. BIRTHPLACE (State or foreign country) Cavetown, Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George M. Bushey		14. MOTHER'S MAIDEN NAME Lucy O. Blessing	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-32-5199		17. INFORMANT Address Ruby S. Bushey, Cavetown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior coronary artery occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial infarction DUE TO (c) Arterio-sclerosis					INTERVAL BETWEEN ONSET AND DEATH 12 hours 10. days 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 25, 1961 , to Sept 26, 1961 , that (I) (we) last saw the deceased alive on Sept 26, 1961 , and that death occurred at 7A M. from the causes and on the date stated above.					
22a. SIGNATURE G. A. Kohler		22b. DATE SIGNED 9-27-61		22c. PHYSICIAN'S NAME (Type) G. A. KOHLER	
22d. ADDRESS Smithsburg Md.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-28-61		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery	
23d. LOCATION (City, town, or county) Smithsburg, Md.		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR SEP 29 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

10731

Wm. Harrison

Under Secy

Washington County, N. H.

Frank

John E. Lacey, Jr.

Male

White

Nov. 11, 1863

Residence

Lumber Company, Concord, N. H.

George W. Lacey

John C. Lacey

Age

21-25

Nov. 11, 1863

Concord, N. H.

10731-2

Washington County, N. H.

Wm. Harrison & Son, Concord, N. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10728 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Pennsylvania b. COUNTY Fulton		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Mc Connellsburg		
c. LENGTH OF STAY IN 1b few hours			d. STREET ADDRESS R.F.D. # 1		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First DANIEL Middle RUSSELL Last BUTERBAUGH			4. DATE OF DEATH Month September Day 27 Year 19 61		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH October 21, 1956		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Fulton Co., Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William G. Buterbaugh		14. MOTHER'S MAIDEN NAME Rosetta Crosslin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT William G. Buterbaugh Address Rural Mc Connellsburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of base of skull with involvement of cord DUE TO (b) 910.0 DUE TO (c) Condillons, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Pt. was pinned beneath rolling log.			
20c. TIME OF INJURY Month, Day, Year Hour 4 p.m. 9/27/ 19 61		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) McConnellsburg, Fulton, Pa.		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE E. W. Ditto, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/28/61	
EXAMINER'S NAME (Type) E. W. Ditto, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/1961		22c. NAME OF CEMETERY OR CREMATORY Union Cemetery	
22d. LOCATION (City, town, or country) Mc Connellsburg, Pa.		22e. (State)			
23. FUNERAL DIRECTOR Suter - Rouzer Funeral Home		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR OCT 5 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. House					



Washington

Washington County, Virginia

White

Male

Virginia, Washington

None

None

Residence

Washington, D.C.

1900

Washington, D.C.

Washington

Washington, D.C.

Washington, D.C.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SAN MAR c. LENGTH OF STAY IN 1b 7 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAHNEY - KEDDY MEMORIAL HOME		2. USUAL RESIDENCE (Where deceased lived, if institution, give name and address) e. STATE MARYLAND f. COUNTY WASHINGTON g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SHARPSBORO h. STREET ADDRESS 1 MAIN ST. i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GRACE HAUSE BUXTON First Middle Last 4. DATE OF DEATH SEPT. 24, 1961 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH JUNE - 6 - 1880 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR: Months 3 Days 18 Hours Min. 	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE KEEPER 11. BIRTHPLACE (County & State, or foreign country) MT. JACKSON VA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME REV. BARTON R. CARNAHAN 14. MOTHER'S MAIDEN NAME ALICE HAUSE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 331X 17. INFORMANT GEORGE C. BUXTON Address 2024 GAY ST. ABERYSTOWN MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO (b) Cerebral Haemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1961 , to Sept 24, 1961 , that (I) (we) last saw the deceased alive on Sept 23, 1961 , and that death occurred at 2 P.M. from the causes and on the date stated above.		22a. SIGNATURE C. W. Levan 22b. PHYSICIAN'S NAME (Type) C. W. Levan 22c. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Boonsboro 22e. DATE SIGNED 9/25/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF SEPT. 26, 1961 23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY 23d. LOCATION (City, town or county) (State) KEEDYSVILLE WASH. CO. MD.		24. FUNERAL DIRECTOR'S SIGNATURE John H. Best ADDRESS BOONSBORO MD. 25a. REC'D BY REGISTRAR OCT 2 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

10718

10718

WASHINGTON

WASHINGTON

2nd Mail

1 week

2nd Mail

Handy ready memoranda form

Handy ready

CLARE HADGE DUNTON

CLARE HADGE DUNTON

George White

X

June - 6 - 1888 81 3-12

Home Keep Own Home

MT. ALBERT VA

REV. BARTON R. CARMICHAEL

ALICE HADGE

No

George C. Burton

Washington

George C. Burton
Washington

George C. Burton
Washington, D.C.
10718

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

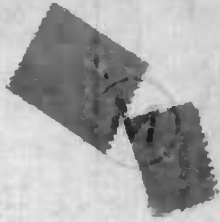
10724

11910

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1911 Dennis Avenue</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b			a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>			4. DATE OF DEATH <u>SEPT 29 1961</u>		
3. NAME OF DECEASED (Type or print) <u>CONSTANCE</u> First <u>CAPORALETTI</u> Middle Last			9. AGE (In years last birthday) <u>31</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>	
13. FATHER'S NAME <u>Ferdinando Carlato</u>		14. MOTHER'S MAIDEN NAME <u>Teresa Conti</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-36-8707</u>		17. INFORMANT <u>Husband</u> Address <u>Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> 343X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POSTINFECTIOUS ENCEPHALITIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>26 MONTHS</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1-21-</u> <u>1960</u> to <u>9-29-</u> <u>1961</u> , that (I) (the) last saw the deceased alive on <u>9-29</u> <u>1961</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.					
22a. SIGNATURE <u>Antonio U. Pallagrosi</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>		22d. ADDRESS <u>1500 Pa Ave Hagerstown MD.</u>			
23a. BURIAL, CREMATION, / 23b. DATE THEREOF <u>10/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET</u>		23d. LOCATION (City, town or county) <u>WASH DC</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rinaldi FH</u> ADDRESS <u>816 H ST NE</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>	

VR A15 (4)
15M 9/60

1932



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Wm. H. Hall
Rm. 111
Wm. H. Hall
Rm. 111
Wm. H. Hall
Rm. 111

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 17

10717

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cavetown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Jane Last Carbaugh		4. DATE OF DEATH Month Sept. Day 17, Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1941
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY sporting goods	
11. BIRTHPLACE (State or foreign country) Cavetown, Md.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Morris Cline		14. MOTHER'S MAIDEN NAME Gaynell Pryor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-40-0565	
17. INFORMANT Mrs. Mary Dietz, Smithsburg, Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock With Intra Abdominal Hemorrhage Due To DUE TO Perforation Of Abdominal Aorta By Bullet. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient Shot By Husband.	
20c. TIME OF INJURY Month, Day, Year 7:10 p. m. 9-17-1961		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Cavetown, Washington, Md. (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-20-61	
22c. NAME OF CEMETERY OR CREMATORY Cavetown Reformed Cem.		22d. LOCATION (City, town, or county) Cavetown, Md. (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS 	
24a. REC'D BY REGISTRAR SEP 21 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Minna	

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS



Form with multiple sections for recording vital statistics, including fields for name, date, sex, age, and cause of death. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise. The text is mirrored across the page, suggesting a bleed-through from the reverse side. Key sections include:

- Top section: Fields for name, date, sex, and age.
- Middle section: Fields for cause of death and other medical details.
- Bottom section: Fields for signature and official use.

The form is divided into several columns and rows, with some areas containing checkboxes and other specific data entry points. The overall layout is complex due to the orientation and mirroring of the text.

10726

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10718

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R2 Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs</u>		d. STREET ADDRESS <u>415 Cedarcroft Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hawthornwood Church Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oda</u> Middle <u>N.</u> Last <u>Conner</u>		4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/76</u>
9. AGE (In years last birthday) <u>8.5</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Walhersville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Stauffer</u>		14. MOTHER'S MAIDEN NAME <u>Clare Neidig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>George A. Conner</u>	
17. INFORMANT <u>Lahe Thoe D. Pasadena md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerosis Gen</u> DUE TO (c) <u>Cerebral Hemorrhage</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>years</u> <u>2 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 58</u> to <u>Sept 5</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Sept 5</u> , 19 <u>61</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis G. Graff, M.D.</u>		22b. DATE SIGNED <u>5 Sept, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Louis G. Graff, M.D.</u>		22d. ADDRESS <u>119 E. Antietam St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET</u>	23d. LOCATION (City, town, or county) (State) <u>FREDRICK MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. L. Etcheson</u>		25a. REC'D BY REGISTRAR <u>SEP 8 '61</u>	
ADDRESS <u>Fredrick Md.</u>		25b. REGISTRAR'S SIGNATURE <u>C. Thos. J. Harris</u>	

(M)

(I)

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Handwritten signature

CHIEF OF POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10727

10719

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 60 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN		
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1 915 DEWEY AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VICTOR Middle MILLER Last CROMER				4. DATE OF DEATH Month SEPTEMBER Day 10 Year 61			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1873		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SILK WEAVER			10b. KIND OF BUSINESS OR INDUSTRY SILK MILL		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN H. CROMER				14. MOTHER'S MAIDEN NAME AMANDA DUFFY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-7570		17. INFORMANT MRS. CATHERINE BLACKBURN		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia (Bilateral) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease with failure DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 4 days 4-5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Sept 6 , 19 61 , to Sept 10 , 19 61 , that I last saw the deceased alive on Sept 9 , 19 61 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 230 N Potomac St, Hagerstown Md DATE SIGNED 11 Sept 61 ACTUAL SIGNATURE F F Lusby PHYSICIAN'S NAME (Type) F F Lusby							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/12/61		22c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne				ADDRESS Hagerstown, Md		24a. REC'D BY REGISTRAR DATE SEP 14 '61	
				24b. REGISTRAR'S SIGNATURE Charles E. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 20, 1961	23c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY	23d. LOCATION (City, town or county) (State) BOONSBORO WASH. CO. MD
24. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Best</i>		25a. REC'D BY REGISTRAR SEP 25 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 17 Sept 1961 to 18 Sept 1961 , that (I) (we) last saw the deceased alive on 17 Sept 1961 , and that death occurred at 11:55 A.M. from the causes and on the date stated above.	
22a. SIGNATURE <i>J. D. Wilson</i>	22b. DATE SIGNED 9/18/61
22c. PHYSICIAN'S NAME (Type) J. D. Wilson, M.D.	22d. ADDRESS 135 North Potomac Street, Hagerstown, Md.
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MARY MANNER Address 120 S. POTOMAC ST. HAGERSTOWN MD
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13. FATHER'S NAME JAMES MADDAN	14. MOTHER'S MAIDEN NAME MRS. GOLDIE BENTZ
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (County & State, or foreign country) MOLESVILLE FRED. CO. MD.	12. CITIZEN OF WHAT COUNTRY? USA
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9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 5 1 - -	IF UNDER 24 HRS. 19 61
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4. DATE OF DEATH SEPTEMBER 18	5. DATE OF BIRTH APRIL 17 1873
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17 1873
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1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb 2 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL	2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 1120 S. POTOMAC ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH	
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135 N. POTOMAC ST.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 48 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) JACKSON CONV. HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAURICE Middle CLEVELAND Last DIETZ		4. DATE OF DEATH Month SEPTEMBER Day 20 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/10/1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY ELECT. APPLIANCE CO.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT DIETZ		14. MOTHER'S MAIDEN NAME ELIZA WILHELM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 214-09-9358A	
17. INFORMANT MRS. LILLIAN M. DIETZ		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis obliterans Heart Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic nephrosclerosis. (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 4 years. 9 years. 7 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inguinal Abscess - Rt.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19 61 to Sept 20 19 61 , that I last saw the deceased alive on Sept 19 19 61 , and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul J. Holman		ADDRESS (Street, city or town, State) 159 W. Washington St. Hagerstown Md.	
PHYSICIAN'S NAME (Type) W. J. Horment		DATE SIGNED 9/23/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/23/61	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment		24a. REC'D BY REGISTRAR DATE SEP 25 '61	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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JACKSON TOWN, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

death. [redacted] may be retained by the hospital or attending physician.
[redacted] to **FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) e. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Williamsport		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 28 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport Sanitarium		d. STREET ADDRESS 912 Potomac Ave.	
3. NAME OF DECEASED (Type or print) SEVERINO S. DOMENICI		4. DATE OF DEATH Month September Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 29, 1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 03 Days 03	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Dealer		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (County & State, or foreign country) Lucca, Italy
13. FATHER'S NAME Richard Domenici		14. MOTHER'S MAIDEN NAME Bernadette Brachini	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Maurice R. Domenici		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral lobar pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) general arteriosclerosis + cerebral DUE TO (c) thrombosis		INTERVAL BETWEEN ONSET AND DEATH 6 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) @ Ch. Cholelithiasis @ Senility @ prostatic hypertrophy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from June 28, 1960 to Sept 16, 1961 , that (I) (we) last saw the deceased alive on Sept 12, 1961 , and that death occurred at 12:30 P.M. from the causes and on the date stated above			
22a. SIGNATURE Edward W. Ditto III		22b. DATE SIGNED 9/18/61	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington St. Hag. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/19/1961	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		25. REC'D BY REGISTRAR SEP 20 1961	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Washington, D.C. Arlington, Va. Washington, D.C.

Washington, D.C. Arlington, Va. Washington, D.C.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10731
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. STREET ADDRESS 640 George Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martin Middle Luther Last Drenner				4. DATE OF DEATH Month Sept. Day 13 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 9 Days 28		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Shoe Co.		11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Silas Drenner				14. MOTHER'S MAIDEN NAME Mary Jane Domer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217 10 2560		17. INFORMANT 640 George St. Md. Mrs. Snna Elizabeth Drenner Hagerstown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Cardiovascular Dis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Generalized Arteriosclerosis. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 9 Mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 8, 1960 to Sept. 13, 1961 that (I) (we) last saw the deceased alive on Sept. 13, 1961 , and that death occurred at 1P M, from the causes and on the date stated above.							
22a. SIGNATURE R.A. Bell				22b. DATE SIGNED 9-15-61			
22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.				22d. ADDRESS 119 N. Potomac St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16-61		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williams, Md.				25a. REC'D BY REGISTRAR DATE SEP 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CRIMINAL RECORD

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Item 1 Film G297 10/9/61 ink									
1. PLACE OF DEATH a. COUNTY <u>Washington</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if instituting, residence before admission) a. STATE <u>Penna.</u>		b. COUNTY <u>Dauphin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		5. STREET ADDRESS	
Termal Restaurant, 123 Elizabeth St.		First Middle Last		911 Norwood Street		Month Day Year		September 30 1961	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>68</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
Reading R.R. Conductor		Railroad		Cumberland Co. Pa.		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
David Dutery		Clara Lehman		No		715-18-0505		Mrs. Miriam Scott, Harrisburg, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>OCCCLUSION LEFT CORONARY</u> (c) <u>CORONARY ATHEROSCLEROSIS SEVERE</u> <u>CHRONIC RHEUMATIC HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER [Signature] M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-30-61	
EXAMINER'S NAME (Type)		DR. E.W. DITTO, JR.		22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
				Burial		10/4/1961		Rolling Green Cemetery	
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
M.R. ROWLAND		CLEAR SPRING, MD.		OCT 4 '61		Arthur S. Kraus			

(M)

CHRONIC RHEUMATIC HEART DISEASE
CORONARY ATHEROSCLEROSIS SEVERE
OCCLUSION LEFT CORONARY

RECEIPT

D. E. W. DITTMER, JR.

9-20-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10733 CERTIFICATE OF DEATH 10725											
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 16X- d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK d. STREET ADDRESS 8 CANARY ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LAURA A. ELDER						DATE OF DEATH Sept. 28, 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 17, 1905		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife, Weaver, Cotton Mill				10b. KIND OF BUSINESS OR INDUSTRY GEORGIA				11. BIRTHPLACE (County & State, or foreign country) U.S.A			
13. FATHER'S NAME BYRD ALLEN						14. MOTHER'S MAIDEN NAME ANNIE GUNNER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. 254-01-9344					
17. INFORMANT Mrs. Onie E. Allen						Address Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ABDOMINAL CARCINOMATOSIS 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF RECTUM DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PYOHYDRONEPHROSIS BILATERAL										INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 3 YEARS	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 21, 1961 to Sept. 28, 1961 , that (I) (we) last saw the deceased alive on Sept. 28, 1961 , and that death occurred at 3:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Antonio U. Pallagrosi M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI						22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF Oct 2, 1961		23c. NAME OF CEMETERY OR CREMATORY ALVESTA CEMETERY			23d. LOCATION (City, town or county) (State) GAINSVILLE, GEORGIA		
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale, Maryland						25a. REC'D BY REGISTRAR OCT 2 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

(M)

10733

10733

WASHINGTON

Page 10000

WASHINGTON

Page 10000

(1)

FEMALE WHITE

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July 10, 1907

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GERMAN

U.S.A.

BORN ALLEN

ANNIE GUNNER

NO

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10734

CERTIFICATE OF DEATH

10726

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 Hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1426 West Franklin St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA EDNA EVERLY				4. DATE OF DEATH Month Day Year Sept 13 1961 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10 1895	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Broad Top Bedford Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Towson				14. MOTHER'S MAIDEN NAME Jennie Foster			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No --		16. SOCIAL SECURITY NO. 220-10-3139		17. INFORMANT Mrs Margaret Nicewander Address 130 E. First Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 420.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 hrs 3-4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 61 to 9/13 , 19 61 that (I) (we) last saw the deceased alive on 9/13 , 19 61 , and that death occurred at 2:30 PM from the causes and on the date stated above.							
22a. SIGNATURE Paul Harrison M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.				22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR SEP 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10735

CERTIFICATE OF DEATH

10727

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN 1b 90 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 55 S. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Blanch Middle Wishard Last Ferguson		4. DATE OF DEATH Month Sept. Day 4, Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25th, 1871
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Smithsburg Md.	
11. BIRTHPLACE (State or foreign country) Smithsburg Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William O. Donaldson		14. MOTHER'S MAIDEN NAME Adelaide E. Wishard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Charles I. Wolfinger, Smithsburg, M		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH 3 years unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 31, 1961 to Sept 2, 1961 , that (I) (we) last saw the deceased alive on Sept 2, 1961 , and that death occurred at 6:20 AM , from the causes and on the date stated above.			
22a. SIGNATURE E. P. Lardizabal		22b. DATE SIGNED 9-5-61	
22c. PHYSICIAN'S NAME (Type) E. P. Lardizabal		22d. ADDRESS 12 So. Main, Smithsburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-6-61	
23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		25a. REC'D BY REGISTRAR SEP 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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DOI: 10.1002/for

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10736

10728

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 36 Nottingham Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1118 N. Mulberry Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First EDNA Middle FISHER Last 4. DATE OF DEATH September 24 Month 19 61 Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH February 28, 1883 9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Mechanicsburg, Penn. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Pentz 14. MOTHER'S MAIDEN NAME Catherine Prosser		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 214-09-3942D 17. INFORMANT Clyde E. Warner Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arterio Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-10, 1961, to 9-24, 1961, that (I) (we) last saw the deceased alive on 9-23, 1961, and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. E. W. P. T. O. J. M.D. 22b. DATE SIGNED SEP 27 1961		22c. PHYSICIAN'S NAME (Type) Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/26/1961 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery 23d. LOCATION (City, town or county) (State) Hagerstown Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home ADDRESS Hagerstown, Maryland 25a. REC'D BY REGISTRAR SEP 27 1961 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VR A15 (4)
15M 9/60

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Washington

Washington

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Female White

Horowitz

George Bentz

no

211-00-1000

Office of the Attorney General

Department of Justice

Department of Justice

Department of Justice

February 28, 1963

September 21

14 days

Department

118 N. Main Street

10722

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10737
10729

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Md. State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Daysville</u> d. STREET ADDRESS <u>10X-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Walter Rudolph Fogle</u> First Middle Last		4. DATE OF DEATH <u>Sept. 5, 1961</u> Month Day Year		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11, 1895</u> yrs.		9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Employed</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Fred. Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Walter Fogle</u>				14. MOTHER'S MAIDEN NAME <u>Alice M. Clem.</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>											
16. SOCIAL SECURITY NO. <u>no</u>				17. INFORMANT <u>Mrs Rudolph Fogle, Walkersville, Md.</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma Recto sigmoid generalized</u> 154 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>carcinomatosis</u> DUE TO (c) <u>5 years</u> INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)									
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1961</u> , to <u>Sept. 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 5, 1961</u> , and that death occurred at <u>7:28 PM</u> , from the causes and on the date stated above.												22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>				22b. DATE SIGNED <u>Sept. 5, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>				22d. ADDRESS <u>Western Md. State Hospital, Hagerstown, Maryland</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glade cemetery</u>		23d. LOCATION (City, town or county) <u>Walkersville</u>		(State) <u>Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>G.C. Barton, Walkersville, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>SEP 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>													

10737

10737

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Station had to be repaired

Oct 11, 1912

W M

John M. Smith

Change water to the
to our work

Y.C. Porter, Washburnville, Mo.
10/10/12

10738

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10730

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 916 Lanville St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Louise Last French		4. DATE OF DEATH Month September Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1908
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles C. French		14. MOTHER'S MAIDEN NAME Ruth Shives	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mrs. Ruth S. French - Cherry Run, W. Va.		Address (Mother)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 241X DUE TO Cardiorespiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asthma and DUE TO Arteriosclerotic heart disease (c) Indefinite.		INTERVAL BETWEEN ONSET AND DEATH minutes. 5-6 hours. 10 years Indefinite.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema; generalized hypertrophic arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from L955 19____, to death 19____, that (I) (we) last saw the deceased alive on 9-4-61 19____, and that death occurred at 2:45 p.m. on the causes and on the date stated above.			
22a. SIGNATURE Robert F. Keadle		22b. DATE SIGNED 9-6-61	
22c. PHYSICIAN'S NAME (Type) Robert F. Keadle		22d. ADDRESS Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-7-1961	
23c. NAME OF CEMETERY OR CREMATORY Snyders E.U.B. Cemetery		23d. LOCATION (City, town, or county) (State) Morgan County, West Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. K. Brown		25a. REC'D BY REGISTRAR SEP 11 '61	
ADDRESS Martinsburg, W. Va.		25b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH

10732

10030

Washington

Maryland

Hyattsville

Hyattsville

Washington County Hospital

215 Landville St.

Alma

Louise

French

September

White

June 2, 1908

23

House 11111

House

Hyattsville, Maryland

USA

Charles C. French

John French

Mrs. Ruth E. French - Cherry Run, W. Va.

(Mother)

Washington, D.C.

Washington, D.C.

Admission

Admission to hospital

Examination and treatment

1908

10-11

Robert L. French

Robert L. French

Hyattsville, Maryland

9-7-1908

Washington, D.C.

Washington, W. Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 25 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 32 McKee Ave					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 32 McKee Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) EMILY WINEBRENNER GILMER					4. DATE OF DEATH September 14 19 61									
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 17 1893		9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY Retired			11. BIRTHPLACE (Country and State) Jefferson Co W. Va.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Samuel Winebrenner					14. MOTHER'S MAIDEN NAME Mary (No Record)									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) --					16. SOCIAL SECURITY NO. None					17. INFORMANT Dr H.D. Gilmer Address 32 McKee Ave Hagerstown Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 151X IMMEDIATE CAUSE (a) Adenocarcinoma of stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 18 hrs + DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 13 Sept 1961 to 14 Sept 1961 , that (I) (we) last saw the deceased alive on 13 Sept 1961 , and that death occurred 4:20 PM from the causes and on the date stated above.														
22a. SIGNATURE Richard T. Binford M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 15 Sept 61							
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.					22d. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/17/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown Wash go Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown Md.					25a. REC'D BY REGISTRAR SEP 18 '61 DATE		25b. REGISTRAR'S SIGNATURE Arthur E. Kump							



10738

10738

Admission 18 Nov 18

Amoria

X

Richard T. [Signature]
 13 Sept 61
 14 Sept 61
 15 Sept 61
 X

TO TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/55

10740 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VICKIE JEAN GLADHILL		4. DATE OF DEATH SEPTEMBER 12 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/1957
9. AGE (In years lost birthday) 3 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY CHILD	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES E. GLADHILL		14. MOTHER'S MAIDEN NAME MARY SHANK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT MR. CHARLES E. GLADHILL		Address Rt. #4 Hagerstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory & Cardiac Failure DUE TO Poliomyelitis Acute Bulbar. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 60krs (c) 12krs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/11/61 , 19 61 , to 9/14/61 , 19 61 , that I last saw the deceased alive on 9/14/61 , 19 61 , and that death occurred at 3:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. M. Bacon		DATE SIGNED 9/13/61	
PHYSICIAN'S NAME (Type) A. M. BACON JR		ADDRESS (Street, city or town, state) 101 RINGG-S + HAGERSTOWN, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/14/61	22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CHURCH CEM.	22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Herment, Hagerstown, Md.		24a. REC'D BY REGISTRAR SEP 19 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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(I)

TO TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/55

CERTIFICATE OF DEATH

1910

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH JANUARY 10 1910	
NAME OF DECEASED JOHN J. ROBERTSON		SEX MALE	
AGE 47		PLACE OF BIRTH IRELAND	
OCCUPATION LABORER		PLACE OF DEATH ST. JOSEPH'S HOSPITAL	
CAUSE OF DEATH CORONARY DISEASE		MEDICAL ATTENDANT DR. J. J. ROBERTSON	
TIME OF DEATH 11:00 AM		PLACE OF BURIAL ST. JOSEPH'S CEMETERY	
SIGNATURE OF DECEASED (None)		SIGNATURE OF MEDICAL ATTENDANT (None)	
SIGNATURE OF WITNESSES (None)		SIGNATURE OF REGISTRAR (None)	

TO HOSTS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10741

10733

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Rural Sharpsburg d. STREET ADDRESS R.F.D. # 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN EDGAR HALL		4. DATE OF DEATH Month September Day 15 Year 1961	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel L. Hall, Jr.		14. MOTHER'S MAIDEN NAME Marie Kling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Samuel Hall, Jr. Sharpsburg, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory distress 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Embryonic toxic fetalis DUE TO (c) RH factor		INTERVAL BETWEEN ONSET AND DEATH 2 days - 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 14, 1961 to Sept 15, 1961 that (I) last saw the deceased alive on Sept 15, 1961 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Louis G. Graff M.D.		22b. DATE SIGNED 9/15/61	
22c. PHYSICIAN'S NAME (Type) Louis G. GRAFF, M.D.		22d. ADDRESS 119 E. Antietam St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/18/1961	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Hamilton Rouzer ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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M

Washington

Washington

Washington County Hospital

I day

September 1, 1961

DATE

TIME

JOHN

September 1, 1961

I

September 1, 1961

write

file

none

Samuel L. Hall, Jr.

Marie King

none

no

Mr. Samuel Hall, Jr. Baltimore, Maryland

*Reprinted from
Washington Post
K.H. Justice*

Sept 12 61

Sept 14 61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10742
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>4 mos. 19 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived, If institution-Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u> d. STREET ADDRESS <u>727 N. Queen St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillie M. Horeford</u>		4. DATE OF DEATH Month Day Year <u>Sept. 4 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31, 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Schoppert</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Pennell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Claude Horeford</u>		Address <u>Greencastle, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pancreatic Carcinoma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Jaundice ② Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>		20f. (City or town) (County) (State)	
21. I certify that (1) (This hospital) attended the deceased from <u>9-3</u> to <u>9-4</u> , 19 <u>61</u> , that (1) (we) last saw the deceased alive on <u>9-3</u> , 19 <u>61</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>9-4-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		23d. LOCATION (City, town or county) (State) <u>Agers town, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Munch</u>		25a. REC'D BY REGISTRAR <u>SEP 6 '61</u>	
ADDRESS <u>Greencastle Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10743

CERTIFICATE OF DEATH

10735

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 1b 1 year				d. STREET ADDRESS 247 Summit Ave.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 247 Summit Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nettie Gaither Harne				4. DATE OF DEATH Month Sept. Day 12, Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1878	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Smithsburg, Md.	
13. FATHER'S NAME Oliver P. Fiery				14. MOTHER'S MAIDEN NAME Meta F. West			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Frank Harne, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/6/60 , 19 60 , to 9/11 , 19 61 , that (I) (we) last saw the deceased alive on 8/20 , 19 61 , and that death occurred at 11 M, from the causes and on the date stated above.							
22a. SIGNATURE Robert V. H. Campbell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/12/61	
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell				22d. ADDRESS Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-14-61		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				25a. REC'D BY REGISTRAR SEP 15 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

(M)

10742

10735

Washington

Washington

277 2nd St. N.W.

277 2nd St. N.W.

Seattle

Seattle

Seattle, Wash.

Seattle, Wash.

Seattle, Wash.

Seattle, Wash.

Seattle, Wash.

Seattle, Wash.

Seattle

Seattle, Wash.

Seattle, Wash.

Scott E. Minner & Son, Mayersville, N.Y. 11751
Cable News

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10744

Item 1 Film G295 9/25/61 iwk

10736

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Virginia</i> b. COUNTY <i>Arlington</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arlington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Garlock Nursing Home - 241 S. Prospect St.</i>		d. STREET ADDRESS <i>800 S. 21st Street</i> <i>83 X-3</i>	
3. NAME OF DECEASED (Type or print) <i>IDA BELLE HARRIS</i>		4. DATE OF DEATH Month <i>September</i> Day <i>19</i> Year <i>1961</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 21, 1881</i>
9. AGE (In years lost birthday) <i>80</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Augusta, W. Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Isaac Newton Carlyle</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Shenholtz</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Worth Southard</i>		Address <i>1015 S. 22nd St. Arlington, Va.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO (b) <i>Cerebral Arterio Sclerosis</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Arterio Sclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>April 3, 1961</i> to <i>Sept 19, 1961</i> that (I) (we) last saw the deceased alive on <i>Sept 19, 1961</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W. E. W. H. T. J.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>W. E. W. H. T. J.</i>		22d. ADDRESS <i>Arlington, Va.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>9-21-61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>		23d. LOCATION (City, town, or county) (State) <i>Fairfax County, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. C. Gray</i>		25a. REC'D BY REGISTRAR <i>SEP 20 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>		25c. ADDRESS <i>2847 Wilson Blvd. Arlington 1, Virginia</i>	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10745

10737

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA COUNTY BERKELEY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HEDGESVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS ROUTE # 2 (TOMAHAWK)	
3. NAME OF DECEASED (Type or print) EMORY LYNN HEDGES		DATE OF DEATH Month SEPTEMBER Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1904
9. AGE (In years lost by day) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles L. Hedges		14. MOTHER'S MAIDEN NAME Laura Saville	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mabel G. Hedges - (Wife)		Address Hedgesville Rt. 2, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarct. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 10, 1961 to Sept. 22, 1961 , that I last saw the deceased alive on Sept. 22, 1961 , and that death occurred at 3:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 132 N. Potomac DATE SIGNED			
ACTUAL SIGNATURE A. F. Abdullah		M.D. 132 N. Potomac	
PHYSICIAN'S NAME (Type) A. F. Abdullah		Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-24-1961	22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery	22d. LOCATION (City, town, or county) (State) Martinsburg, West Va.
23. FUNERAL DIRECTOR'S SIGNATURE Harold T. Brown		ADDRESS Martinsburg W. Va.	
24a. REC'D BY REGISTRAR DATE SEP 26 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10745

CERTIFICATE OF DEATH

Reg. Dist. No. 10738

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 1875 JEFFERSON BLVD.	
3. NAME OF DECEASED (Type or print) First Middle Last LAFEYETTE E. HERBAUGH		4. DATE OF DEATH Month Day Year SEPTEMBER 26 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/1899
9. AGE (In years lost birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired sheet metal worker	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM D. HERBAUGH		14. MOTHER'S MAIDEN NAME MARY CATHERINE WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 236-01-8648	
17. INFORMANT MRS. MAUDE HERBAUGH		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 42011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C. V. Disease (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 9/23/61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Residual Hemiplegia (Cerebral Thrombosis)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 23, 19 61, to Apr 26, 19 61, that I last saw the deceased alive on Apr 26, 19 61, and that death occurred at 6:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sidney Horvath M.D.		DATE SIGNED 9-27-61	
PHYSICIAN'S NAME (Type) SIDNEY HORVATH, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/28/61	
22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		24a. REC'D BY REGISTRAR DATE SEP 29 '61	
ADDRESS Hagerstown Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10747

10739

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN b. <u>10 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>REEDER NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LITTLESTOWN</u> d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>ANNA MAY JONES</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 23 - 1961</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>OCTOBER 29 - 1871</u>		9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u>10</u> Days <u>24</u> Hours <u></u> Min. <u></u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE CARSON</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN SOUDERS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. LESTER REEDER BOONSBORO MD. R. 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> <u>450.0</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>lung years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>Sept 23</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 23</u> , 19 <u>61</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.															
22a. SIGNATURE <u>Joseph Secondary</u>				22b. DATE SIGNED <u>Sept 23 1961</u>				22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>				22d. ADDRESS <u>BOONSBORO MD</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>SEPT 26 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>				23d. LOCATION (City, town or county) <u>BOONSBORO WASH. CO. MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Burt</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 2 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO WARD 2 LITTLE TOWN

REDEEMER NORTON HOME

BOONSBORO MD. 2-2

ANNA MAY JONES

SEPTEMBER 23-1901

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NEAR BOONSBORO WASH. CO. MD.

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BOONSBORO MD

BOONSBORO MD.

REDEEMER NORTON HOME

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Jefferson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeders Nursing Home				d. STREET ADDRESS Shepherdstown 858-3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Robert Magruder Kearney				4. DATE OF DEATH Month Day Year September 24 1961			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 31, 1866		9. AGE (In years last birthday) yrs. 95	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Rocky Marsh, Jeff. Co., W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thornburg Kearney				14. MOTHER'S MAIDEN NAME Martha Randall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Ruth Taylor Address Shepherdstown W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-5- 19 61 to 9-24 19 61 , that (I) (we) last saw the deceased alive on 9-24 19 61 , and that death occurred at 7:30 M, from the causes and on the date stated above.							
22a. SIGNATURE Joseph Secordari				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECORDARI				22d. ADDRESS Boonsboro MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 27, 1961		23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Donald Eckel				ADDRESS Bolivar, W. Va.		25a. REC'D BY REGISTRAR DATE SEP 28 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

10740

UNITED STATES OF AMERICA

10740



Handwritten signature or name, possibly "J. Edgar Hoover".

Handwritten text, possibly "Director, Federal Bureau of Investigation".

U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
JAN 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10749

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 47 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle URSULA Last KINDLE		4. DATE OF DEATH Month SEPTEMBER Day 10 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/20/1894
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH BENDER	
14. MOTHER'S MAIDEN NAME MARY BRUMBACK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 220-05-6227		17. INFORMANT MR. JOHN KINDLE	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular hemorrhage, severe DUE TO (b) Hypertensive arteriosclerotic cardiovascular renal disease. (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 36 hours
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 16 , 19 61 , to Sept. 10 , 19 61 , that I last saw the deceased alive on September 10, 1961 , and that death occurred at 2:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Archie Robert Cohen M.D.	
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D., Clear Spring, Maryland 09/11/61	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 9/13/61	22c. NAME OF CEMETERY OR CREMATORY U.B. CHURCH CEM.	22d. LOCATION (City, town, or county) (State) BENEVOLA WASHINGTON CO. MD
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md		24a. REC'D BY REGISTRAR SEP 14 '61	24b. REGISTRAR'S SIGNATURE Archie R. Cohen

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10750

10742

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b 3 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reeder Nursing Home		d. STREET ADDRESS 75 X-2	
3. NAME OF DECEASED (Type or print) First Daniel Middle C. Last Kline		4. DATE OF DEATH Month Sept. Day 7, Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1871
9. AGE (In years lost birthday) 90 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist	
11. BIRTHPLACE (State or foreign country) Wolfsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam Kline		14. MOTHER'S MAIDEN NAME Susannah Frey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Donald Kline,		Address Blue Ridge Summit Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 3, 1961, to Sept. 7, 1961, that I last saw the deceased alive on September 6, 1961, and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. W. He Van		ADDRESS (Street, city or town, state) Boonsboro	
PHYSICIAN'S NAME (Type) G. W. He Van		DATE SIGNED 9/8/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/10/61	22c. NAME OF CEMETERY OR CREMATORY Harbaugh's	22d. LOCATION (City, town, or county) (State) Smithsburg #2, Franklin Co. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Grove, Waynesboro Pa.		24a. REC'D BY REGISTRAR DATE SEP 11 '61	
		24b. REGISTRAR'S SIGNATURE C. L. H. H. H.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10751

10743

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 MO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WOBBURN MANOR HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANIEL Middle IGNATIUS Last KLINE		4. DATE OF DEATH Month SEPTEMBER Day 27 Year 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1868
9. AGE (In years lost birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BRASS MOLDER		10b. KIND OF BUSINESS OR INDUSTRY FOUNDRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB KLINE		14. MOTHER'S MAIDEN NAME MARTHA SPOPE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT MRS. MARY GLENN		HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7c. Myocardial INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 9/27/61 , 19 61 , to 9/27/61 , 19 61 , that I last saw the deceased alive on 9/27/61 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph F. Young		M.D. William J. Hager DATE SIGNED 9/27/61	
PHYSICIAN'S NAME (Type) RALPH F. YOUNG			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9/30/61	22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE OCT 2 '61	24b. REGISTRAR'S SIGNATURE Arthur S. King

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10752

10744

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> d. STREET ADDRESS <u>#510 Hodges Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First Middle Last <u>LANCLEY</u>				4. DATE OF DEATH <u>SEPT 30</u> 19 <u>61</u> Month Day Year															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26th October '89</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas H. Langley</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Rhinehart</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>216 12 7827</u>				17. INFORMANT <u>Mr. Delbert Langley</u> Address <u>Same As #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> DUE TO (b) <u>PULMONARY EMPHYSEMA</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>6 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that (I) <u>(the deceased)</u> attended the deceased from <u>1-22-</u> <u>1961</u> to <u>9-30</u> <u>1961</u> , that (I) <u>(the deceased)</u> last saw the deceased alive on <u>9-30-</u> <u>1961</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Antonio U. Pallagrosi</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>9/30/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>						22d. ADDRESS <u>1500 Pa Ave Hagerstown, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5th Oct. '61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard L. Langley</u>						25a. REC'D BY REGISTRAR <u>OCT 4 '61</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20752



Washington

Department

Western Maryland State Hospital

John Hodgson

Secretary

Medical

John Adams

10441

25th October 1921

X

Male

Colonel (ret.) Self-Employed

Maryland

Thomas H. Langley

General Manager

1111 11 St SE, Washington, D.C.

John Adams

John Adams Secretary

John Adams

John Adams

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Information from birth cert.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Wayne</u> Last <u>Lescallett</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>26</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1961</u>
9. AGE (In years last birthday) <u>11</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Hospital</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Merle Lescallett</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Irene Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature birth, neonatal death due to</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hyaline membrane.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept. 26, 19 61</u> , to <u>Sept. 26, 19 61</u> that I last saw the deceased alive on <u>Sept. 26, 19 61</u> , and that death occurred at <u>12:35 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>J. Secondari</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>J. Secondari, M.D.</u> <u>Boonsboro, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/30/61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Schaffer, adm. Wash. Co. Hosp.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 3 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. COLOR</p>	
<p>9. RELIGION</p>		<p>10. EDUCATION</p>	
<p>11. PRESENT ADDRESS</p>		<p>12. DATE OF DEATH</p>	
<p>13. CAUSE OF DEATH</p>		<p>14. PLACE OF DEATH</p>	
<p>15. MEDICAL HISTORY</p>		<p>16. SOCIAL HISTORY</p>	
<p>17. SIGNATURE OF PHYSICIAN</p>		<p>18. SIGNATURE OF REGISTRAR</p>	
<p>19. SIGNATURE OF WITNESSES</p>		<p>20. SIGNATURE OF DECEASED</p>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10754

10746

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>one month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Oakland</u> d. STREET ADDRESS <u>R. D. #1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> <u>Harrison</u> <u>LEWIS</u> First Middle Last		4. DATE OF DEATH <u>9</u> <u>25</u> <u>1961</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1881</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer and Woods worker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Phillip Lewis</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Lydia Shaffer</u> 16. SOCIAL SECURITY NO. <u>Cumberland, Md.</u> 17. INFORMANT <u>Mrs. Esther Hiser, Locust Grove</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary arteriosclerosis</u> (b) <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis, Pulmonary emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 24, 1961</u> to <u>Sept. 25, 1961</u> , that (I) <u>was</u> last saw the deceased alive on <u>Sept. 25, 1961</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22b. DATE SIGNED <u>Sept. 25, 1961</u> 22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9/28/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lewis Family Cemetery</u> 23d. LOCATION (City, town or county) <u>7 Mi. N W Oakland, Md.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u>Oakland, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 2 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(7)

10516

10516

Samuel Harrison Lewis

Nov. 22, 1881

William Lewis

joined father and mother

anywhere

Woods, Maine

Stephen Lewis, Boston, Mass.

Charles Lewis, Yarmouth, Nova Scotia

Aug 24, 1881

Sept 27, 1881

Young E. CHUN 1880

Oakland, Cal.

Oct 5

1
M
081
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
10755					10747										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)										
a. COUNTY		Washington			a. STATE		Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown			b. COUNTY		Washington								
c. LENGTH OF STAY IN 1b		most of Life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
Washington County Hospital					216 N. Locust Street										
3. NAME OF DECEASED					4. DATE OF DEATH		5. IS RESIDENCE ON A FARM?								
First		Middle		Last		Month		Day							
WINONA		VERNICE		LEWIS		September		1 1961							
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)							
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 19, 1883		78 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
Housewife							Lowellville, Ohio		U.S.A.						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME										
John Igo					? Baker										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT					
no					none					Mr. Elmer P. Bewis					
										Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction										1 wk.					
153.3 DUE TO (b) Carcinoma Sigmoid										6 mo.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19										While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 1955-9-1 to 1961-9-1, that (I) (we) last saw the deceased alive on 1955-9-1, and that death occurred at 2 P.M. from the causes and on the date stated above.															
22a. SIGNATURE										22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial										9/4/1961		Rose Hill Cemetery		Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Suter - Rouzer Funeral Home										DATE SEP 5 '61		Arthur L. Hennes			
R. Franklin Hennes										Hagerstown, Md.					

10732

Washington

Washington

Washington County, Maryland

Old N. County Court

DEED

WARRANT

1873

September 1

White

July 10, 1873

Housewife

Lowellville, Ohio

John Lee

? John

on

none

Mr. John A. Davis

Washington, D.C.

Post Hill Cemetery

2/1/90

John

John - Housewife

Washington, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10756

10748

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) e. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Md. State Hospital		d. STREET ADDRESS 58 Carver Apts.	
3. NAME OF DECEASED (Type or print) JAMES Joshua MAHAMMITT		4. DATE OF DEATH SEPT 13 1961	
5. SEX Male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-21-1906
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cont. Laborer		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jerry Mahammitt		14. MOTHER'S MAIDEN NAME Carrie Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-0706	
17. INFORMANT James H. Gibson-58 Carver Apts.		Address Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA OF THE ESOPHAGUS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-23-61 to 9-13-61 , that (I) (was) last saw the deceased alive on 9-13-61 , and that death occurred at 4:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi M.D.		22b. DATE SIGNED SEP 13 1961	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 PA. AVE HAGERSTOWN MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-16-61	23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant	23d. LOCATION (City, town or county) (State) Frederick Co. Md.
24. FUNERAL DIRECTOR'S SIGNATURE C.E. HICKS 111		25a. REC'D BY REGISTRAR SEP 18 '61	
ADDRESS Frederick, Md.		25b. REGISTRAR'S SIGNATURE C. E. Hicks	

(M)

Washington

Mr. Tolson

Eastern Md. State Hospital

38 Garver Ave.

John E. Jackson

WATERVILLE

2977

Male

C

4-11-1900

55

Cont. Laborer

Washington

Frederick Co. Md.

U.S.A.

John E. Jackson

Carrie Jackson

Frederick, Md.

217-10-0702 James H. Gibson-38 Garver Ave.

No

Mt. Pleasant

9-10-01

Serial

O.S. HICKS III Frederick, Md.

Frederick Co. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10757

CERTIFICATE OF DEATH

Reg. Dist. No.

10749

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) 2229 VIRGINIA AVE.				d. STREET ADDRESS 2229 VIRGINIA AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES First HAROLD Middle McKENNA Last				4. DATE OF DEATH Month SEPTEMBER Day 8 Year 1961				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/30/1904		
9. AGE (In years lost birthday) 56 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES VINCENT McKENNA				14. MOTHER'S MAIDEN NAME ANNA BELL RHODES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS V. MADELINE McKENNA		Address HAGERSTOWN MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH minutes. indefinite								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. Month 9 Day 9 Year 1961 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from _____, 1958, to death _____, 1961, that I last saw the deceased alive on _____, 1958, and that death occurred at 6:30 A.M. , from the causes and on the date stated above.								
ACTUAL SIGNATURE Robert F. Keadle		ADDRESS (Street, city or town, state) 318 N. Potomac St. M.D.		DATE SIGNED 9-8-61				
PHYSICIAN'S NAME (Type) Robert F. Keadle Hagerstown, Maryland								
22a. BURIAL, CREMATION, REMAINS (Specify) BURIAL		22b. DATE THEREOF 9/11/61		22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CHURCH CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD.		
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR SEP 13 '61		
				24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss				

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10758						10750					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			Washington			a. STATE			Maryland		
			MARYLAND						b. COUNTY		
									Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Hagerstown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Hagerstown		
c. LENGTH OF STAY IN 1b			1 day			d. STREET ADDRESS			1826 Homewood Road		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM?					
Washington County Hospital						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First			Middle			Last			Month Day Year		
MICHAEL			MC KENNA			September			27 1961		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		September 27, 1961		1		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
none								Hagerstown, Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
Joseph H. Mc Kenna				Sophie Ziemba				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
no				none				Mr. Joseph H. Mc Kenna Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
776X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year											
20d. INJURY OCCURRED											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 9/27/1961 to 9/27/1961, that (I) (we) last saw the deceased alive on 9/27/1961, and that death occurred at 205K M, from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type)											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											

VR A15 (4)
15M 9/60

2081352 XVV

M

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10753

10750

Washington

Washington

I am

Washington

Washington County Hospital

1888 Washington Road

MURRAY

NO. 10751

September 27

White

September 27, 1901

none

Washington, D.C.

Joseph H. McNamee

Joseph H. McNamee

no

none

11. Joseph H. McNamee, Washington, D.C.

for Washington 10753

*Q. M. Packer
P. M. Packer Jr.
Sept 27
Sept 27
Sept 27*

White

Sept 27

Good Hill Cemetery

Washington

after - Joseph H. McNamee, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 10751

10759

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>113 N. MULBERRY ST.</u>	
3. NAME OF DECEASED (Type or print) <u>SARAH ELLEN MENTZER</u>		4. DATE OF DEATH <u>SEPTEMBER 15 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPTEMBER 15 1961</u>
9. AGE (In years last birthday) <u>6</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ALAN HENRY MENTZER</u>		14. MOTHER'S MAIDEN NAME <u>SHIRLEY ELLEN DODSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity (1 lb 11 g)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/15/61</u> , 19 <u>61</u> to <u>9/15/61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>9/15/61</u> , 19 <u>61</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. Bacon</u>		ADDRESS (Street, city or town, state) <u>101 King St Hagerstown, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>A. M. BACON JR</u>		DATE SIGNED <u>9/15/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Sept. 16, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WILLIAMSPORT, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert & Leaf Williamsport, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>SEP 18 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081191XVO

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1 M
FOR STATE
HEALTH DEPT.

DR. DITTO JR.
215 W. WASH. ST.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10752											
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 13 YEARS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2300 VIRGINIA AVE.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 2300 VIRGINIA AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ARTHUR W. MIDDLEKAUFF				4. DATE OF DEATH Month Day Year SEPTEMBER 6 1961							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 29 - 1906		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days 10 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR OF GAS STATION				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) FAIRPLAY WASH. CO. MD. U.S.A.			
13. FATHER'S NAME GEORGE W. MIDDLEKAUFF				14. MOTHER'S MAIDEN NAME ANNIE KESSELRING				Address 2300 VA. AVE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 577-05-8192				17. INFORMANT MRS. LENA P. MIDDLEKAUFF HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion rt. old & recent Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary Atherosclerosis (c) Myocardial Infarct healed PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
12a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				12b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
12c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				12d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		12e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		12f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 9-8-61			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Boonsboro MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF SEPT. 9 1961		22c. NAME OF CEMETERY OR CREMATORY BAKERSVILLE CEMETERY		22d. LOCATION (City, town, or country) BAKERSVILLE WASH. CO. MD.			
23. FUNERAL DIRECTOR John H. Bast				ADDRESS Boonsboro MD.		24. REC'D BY REGISTRAR SEP 13 '61		24b. REGISTRAR'S SIGNATURE Anthony L. House			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Dianna Grace Nichols		4. DATE OF DEATH Month Day Year Sept. 19 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1958
9. AGE (In years lost birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3 Days 4 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Richard Nichols		14. MOTHER'S MAIDEN NAME Anita Obitts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert R. Nichols Hagerstown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Polio myelitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While o. m. p. m. of work <input type="checkbox"/> Not while o. m. p. m. of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/19/61 to 9/19/61 , that (I) (we) last saw the deceased alive on 9/19/61 and that death occurred on 9/19/61 from the causes and on the date stated above.			
22a. SIGNATURE Ralph Young		22b. DATE 9/20/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1961	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Williamsport, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md		25a. REC'D BY REGISTRAR SEP 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hance			

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CENTRAL OF DEATH

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Washington

Kentland

Washington



Washington

Home

Washington

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950 Lawrence St.

Washington County Hospital

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Sept. 19

Nichols

Grace

Dianna

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June 19, 1958

Female White

Washington, Kentucky USA

Home

Antia Obita

Robert Richard Nichols

950 Lawrence St.

Robert R. Nichols, Washington, Mo.

Home

No

Handwritten signature: Robert R. Nichols

Handwritten signature: [illegible]

Large handwritten signature: Robert R. Nichols

Robert R. Nichols, Washington, Mo. Sept. 21, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> c. LENGTH OF STAY IN 1b <u>60 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>208 N. MAIN ST.</u>												2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u> d. STREET ADDRESS <u>208 N. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>EDITH PEARL NIKIRIK</u> First Middle Last 4. DATE OF DEATH <u>SEPTEMBER-25 1961</u> Month Day Year												5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>NOVEMBER-11-1878-82</u> If UNDER 1 YEAR: Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MIDDLEBURY WASH. CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>												13. FATHER'S NAME <u>MCCARTIN</u> 14. MOTHER'S MAIDEN NAME <u>NO RECORD</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NO RECORD</u> 17. INFORMANT <u>JOHN GOLDEN</u> Address <u>208 N. MAIN ST. BOONSBORO MD.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DISSECTING ANEURYSM of AORTA</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH. <u>20 minutes</u> <u>many years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertension</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Sept 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 25</u> , 19 <u>61</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>Joseph Secundari</u>												22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>												22d. ADDRESS <u>BOONSBORO MD</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>												23b. DATE THEREOF <u>SEPT-28-1961</u>											
23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>												23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Post</u>												25a. REC'D BY REGISTRAR <u>OCT 2 '61</u>											
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>																							

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JOHN GOLDEN

208 N. Main St
Baltimore MD

INVESTIGATING AGENCY OF MORTG

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Baltimore MD
Baltimore Cemetery
Baltimore MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10763					10755						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Washington MARYLAND					a. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown						
c. LENGTH OF STAY IN 1b 50 years					d. STREET ADDRESS 25 Broadway						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 25 Broadway					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
DOROTHY			SCHINDEL		NISSLEY		September 21		1961		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 14, 1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Librarian				10b. KIND OF BUSINESS OR INDUSTRY County Library		11. BIRTHPLACE (County & State, or foreign country) Harrisburg, Penn.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H. L. Nissley					14. MOTHER'S MAIDEN NAME Clara J. Schindel						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 220-10-1474		17. INFORMANT		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion										Instant	
420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease										Indefinite	
(c) Arteriosclerotic heart disease										Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		Month, Day, Year 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1948 to Sept. 21, 1961 , that (II) (we) last saw the deceased alive on Aug. 1, 1961 , and that death occurred at 5 P.M. from the causes and on the date stated above.											
22a. SIGNATURE B. B. Kneisley					M.D. B. B. Kneisley, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/22/61		
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.					22d. ADDRESS 148 West Washington Street Hagerstown, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/23/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer					ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE SEP 25 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10764

10756

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 55 years		d. STREET ADDRESS 119 N. Foundry St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Charles Norris, Sr.		4. DATE OF DEATH Month Sept. Day 25 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1905
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) freight dept.		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? 20 years	
13. FATHER'S NAME Charles E. Norris		14. MOTHER'S MAIDEN NAME Ida Mae Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1924-25	
17. INFORMANT Vivian L. Norris, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma and Acute Yellow Atrophy 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the Liver DUE TO (c) Alcoholism PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pancreatitis and Old Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 3 days Indeterminate 20 years			
20c. TIME OF INJURY Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) W. J. Layman attended the deceased from Sept. 22, 1961 to Sept. 25, 1961 , that (I) (we) last saw the deceased alive on Sept. 25, 1961 , and that death occurred at 4:20 pm , from the causes and on the date stated above.			
22a. SIGNATURE W. J. Layman		22b. DATE SIGNED 9-26-61	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-27-61	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR SEP 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

(M)

10764

0758

Washington

No.

Rank

Washington

22 years

Washington

Washington County Hospital

110 W. Twenty St.

William Charles

Kerris, Sr.

Sept. 22, 1905

White

Dec. 23, 1905

Freight Agent

Washington, D.C.

Charles E. Kerris

110 W. Twenty St.

1905-06

217-10-3302

William I. Kerris, Washington, D.C.

Medical Officer, U.S. Army

Medical Officer, U.S. Army

Medical Officer, U.S. Army

Medical Officer, U.S. Army

U.S. Army

1905-06

1905-06

9-25-01

St. View Cemetery

Washington, D.C.

Scott I. Winnick & Son, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
e. COUNTY				e. STATE			
WASHINGTON MARYLAND				MARYLAND WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
NEAR DOWNSVILLE		3 YEARS		FUNKSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
WOBBURN MANOR HOME							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
THOMAS HERBERT OSBORNE				SEPTEMBER 18, 1961			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		AUG. 14, 1874	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
ATTENDANT		GAS STATION		WASH. CO. MD.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
THOMAS OSBORNE				ELLEN GIMPLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
NO				213-01-1053			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]				17. INFORMANT			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)				Address			
420.1 DUE TO				MRS. JOSEPH TROXELL FUNKSTOWN MD.			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.				Ac. Myocardial Infarction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH			
				IMMEDIATE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				19. WAS AUTOPSY PERFORMED?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
19							
21. I certify that (I) (this hospital) attended the deceased from 9/18/61 to 9/18/61, that (I) (we) last saw the deceased alive on 9/18/61, and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
Ralph Young M.D.				9/19/61			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
BURIAL		SEPT. 21, 1961		FUNKSTOWN CEMETERY		FUNKSTOWN WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
John D. Best				SEP 25 61			
25b. REGISTRAR'S SIGNATURE				DATE			
Curtis A. Pringle							

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WASHINGTON

WASHINGTON

NEAR DAVENPORT 5 YEARS

FOUNTAIN TOWN

1708 1/2 WINDY HOME

THANKS

HERBERT

OSBORNE

SEPTEMBER 1911

MALE WHITE

AUG 14 1874 27 1 1/2

ATTENDANT

GAS STATION

WASH. CO. MD.

W.F.A.

THOMAS OSBORNE

ELLEN J. WHITE

NO

213-01-1023 Mrs. Joseph Thomas FOUNTAIN TOWN

He. and family in FOUNTAIN TOWN

11/10/12

11/10/12

11/10/12

11/10/12

11/10/12

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10766

10758

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown R # 1</u>		c. LENGTH OF STAY IN 1b <u>24 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown R # 1</u>		d. STREET ADDRESS <u>Hagerstown R # 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Emerson Peck</u>				4. DATE OF DEATH Month Day Year <u>Sept. 3 19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>January 26, 1912</u>		9. AGE (In years last birthday) <u>49 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Uniontown, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Algy Ray Peck</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fillebaum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>178-05-8352</u>		17. INFORMANT Address <u>David L. Peck Hagerstown R # 1 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Resection Terminal ileum for megacolon</u> (c) <u>Mural Thrombus & Rheumatic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>small 21 June 61</u> <u>21 June 61</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>21 June 1961</u> to <u>3 Sept. 1961</u> , that (I) (we) last saw the deceased alive on <u>3 Sept. 1961</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank E Brumback</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>4 Sept 61</u> 22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Frank E Brumback</u>				22d. ADDRESS <u>190 West Washington St</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>C. G. H. H.</u>			

Wm. G. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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178-77-292

Handwritten notes:
The following is a list of the names of the persons who were present at the meeting held on the 1st day of June, 1901, at the residence of Mr. J. H. Smith, 1234 Main Street, New York City.

Handwritten notes:
The following is a list of the names of the persons who were present at the meeting held on the 1st day of June, 1901, at the residence of Mr. J. H. Smith, 1234 Main Street, New York City.

CERTIFICATE OF DEATH

Reg. Dist. No. **410759**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Conv. Hospital		d. STREET ADDRESS MARION, PA. 75X-3	
3. NAME OF DECEASED (Type or print) IRA A. PICKING		4. DATE OF DEATH Sept 6/61 19 19	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1883
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTH PLACE (State or foreign country) Franklin Co., Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred W. Picking		14. MOTHER'S MAIDEN NAME Lundia Statler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 162-22-2852	
17. INFORMANT John F. Picking - Marion, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis DUE TO (c) Hypertensive Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH 15 days unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis ; Pneumonitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 24 , 19 61 , to Sept. 6 , 19 61 , that I last saw the deceased alive on Sept. 6 , 19 61 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. T. Layman		ADDRESS (Street, city or town, state) 5 Public Square Hagerstown, Md.	
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		DATE SIGNED 9-8-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/61	
22c. NAME OF CEMETERY OR CREMATORY Brown's Mill Cem.		22d. LOCATION (City, town, or county) (State) Kauffman Station, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Munnich - Greencastle, Pa.		24a. REC'D BY REGISTRAR DATE SEP 13 '61	
24b. REGISTRAR'S SIGNATURE Charles E. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10760

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dargon c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dargon d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles William Edward Ramsburg			4. DATE OF DEATH Month 9 Day 4 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1900	9. AGE (In years last birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 4 Days 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman B.&O.R.R.Co			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (County & State, or foreign country) U.S.A.
13. FATHER'S NAME Charles M. Ramsburg			14. MOTHER'S MAIDEN NAME Carrie May Long		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Mrs. Mary E. Ramsburg,		
17. INFORMANT Mrs. Mary E. Ramsburg,			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 2377 DUE TO secondary to Concomitant, if any, which gave rise to immediate cause (b) Neurogenic brain tumor. (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Surgery performed several mos ago.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-10-61 , 19 19 , to 8-31-61 , 19 19 , that (I) (we) last saw the deceased alive on 8-31-61 , 19 19 , and that death occurred at M , from the causes and on the date stated above.					
22a. SIGNATURE Jules E. Langlet, MD.			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Jules E. Langlet
22d. ADDRESS 206 W. Liberty St. Charles Town, W. Va.			22e. REC'D BY REGISTRAR SEP 11 '61		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-7-1961		23c. NAME OF CEMETERY OR CREMATORY Park Heights
23d. LOCATION (City, town or county) Brunswick, Maryland			23e. REGISTRAR'S SIGNATURE Arthur S. Kraus		
24. FUNERAL DIRECTOR'S SIGNATURE B. H. Felt			24b. ADDRESS Brunswick, Maryland		

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10769

10761

1. PLACE OF DEATH e. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Md. b. COUNTY Pr. Geo. County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 6903 20th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Flora Elsie Richter		4. DATE OF DEATH Month Day Year 9 19 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/1909
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days 52	IF UNDER 24 HRS. Hours Min. 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter Ward Wessells		14. MOTHER'S MAIDEN NAME Mary Elizabeth Nelson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT Claude W. Wessells, 6903 20th Ave., Hyattsville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia, bilateral 191.5 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Epidermoid carcinoma of anus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident & hemiplegia (b) chronic pyelonephritis + hydronephrosis, bil.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 24, 1960 to Sept. 19, 1961 , that (I) two saw the deceased alive on Sept. 19, 1961 , and that death occurred at 9:14 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED Sept. 20, 1961	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9/23/1961	
23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Wash 9, D.C.		25a. REC'D BY REGISTRAR SEP 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

M

10769

10761

Washington

Washington

Western Md. State Hospital

6003 2nd Ave.

FLOYD

ELISE

KITCHER

People's Union

WASH. D.C.

Washington

Washington

Walter Reed Hospital

Walter Reed Hospital

Obituary, Washington Post

Epithelial carcinoma of cervix

Obituary, Washington Post

March 24 to April 19 41

P.H.

United States
Vice & Consular

U.S. Department of State

Mr. Wm. C. Cress, D.C.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
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10770
10762
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Myrtle Middle Landela Last Roberts				4. DATE OF DEATH Month 9 Day 9 Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-3-1908	
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Harry E. Mulligan				14. MOTHER'S MAIDEN NAME Cora Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-16-0177		17. INFORMANT Louis A Roberts Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH 4 hours, 4 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9/7 19 61 to 9/9 19 61 , that (I) (we) last saw the deceased alive on 9/9 19 61 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE J. D. Wilson				22b. DATE SIGNED 9/10/61			
22c. PHYSICIAN'S NAME (Type) J. D. Wilson, M.D.				22d. ADDRESS 135 N. Potomac St Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-12-61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Rowland				ADDRESS Clear Spring, Md.		25a. REC'D BY REGISTRAR DATE SEP 14 '61	
				25b. REGISTRAR'S SIGNATURE Charles E. Howard			

(M)

10770

UNITED STATES OF AMERICA

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ATTEST: Notary Public for the State of New York

1911

Wm. J. ...

Notary Public

1911

Wm. J. ...

Notary Public

1911

Wm. J. ...

Notary Public

1911

Wm. J. ...

Notary Public

1911

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2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10772					10764						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)						
a. COUNTY		WASHINGTON			e. STATE		b. COUNTY				
		MARYLAND			MARYLAND		WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
HAGERSTOWN			LIFE		HAGERSTOWN						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
WESTERN MARYLAND STATE HOS.					1 HOTEL HAMILTON						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			MARY		SHANNE		BERGER		SEPT 8 1961		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		OCT 22 1872		88 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
COURT STENOGRAPHER								WASH. CO., MARYLAND		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
UNKNOWN					UNKNOWN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO.					HOSPITAL RECORDS						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR PNEUMONIA										12 DAYS	
170X DUE TO (b) CARCINOMA OF RIGHT BREAST										4 MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		
Hour e.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						(State)		
21. I certify that (I) (the hospital) attended the deceased from 5-18 1961, to 9-8 1961, that (I) (the) saw the deceased alive on 9-8 1961, and that death occurred at 10:15 AM, from the causes and on the date stated above.											
22a. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
ANTONIO U. PALLAGROSI					1500 Pa AVE HAGERSTOWN MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)		
BURIAL			9/12/61		ROSE HILL CEMETERY		HAGERSTOWN		MD.		
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. Franklin Boyer					HAGERSTOWN, MD.			DATE SEP 18 '61		Arthur S. F...	

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MAY

SHAWNEE BEACH

SEIT

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61

GET TO 1272 14

LEAVE 1272

END OF LINE

W. J. H. H.

W. J. H. H.

LEAVING 1272

CRASHING ON RIGHT 1272 - 1272

12-18

12-18

61

12-18

ALICE W. H. H.

ALICE W. H. H. 1272 1272 1272

W. J. H. H. 1272 1272 1272

W. J. H. H. 1272 1272 1272

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TO HOPEAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10773
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10765

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 58 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 413 Summit Ave. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Iona English Shilling		4. DATE OF DEATH Sept. 22 19 61		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Lovettsville, Va.				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Irvin I. English				14. MOTHER'S MAIDEN NAME Jessie Smith				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None				17. INFORMANT Harry I. Shilling Hagerstown, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver (Portal) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.												INTERVAL BETWEEN ONSET AND DEATH 17 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept. 22, 1961 to Apr. 26, 1961 and that death occurred at 9a.M. from the causes and on the date stated above.																			
22a. SIGNATURE R.A. Bell, M.D.				22b. DATE SIGNED Sept. 22, 1961				22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.				22d. ADDRESS 119 N. Potomac St. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-24-61				23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE SEP 26 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

10785

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Washington

Washington

Washington

Washington

Washington

Washington County Hospital

Washington Ave.

John

English

Shilling

Scott

Female White

Feb. 1, 1893

Home Wife

One Home

Loveville

Living I. English

Female White

None

Harry I. Shilling

Washington

Director of State Hospital

Home

Scott

R.A. Bell, M.D.

115 S. Second St., Washington, D.C.

1930-31

None All Cemetery

Washington, D.C.

Scott I. Minnich & Son

Washington, D.C.

CERTIFICATE OF DEATH

Reg. 10774
10786

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>				d. STREET ADDRESS <u>08X-2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HARVEY</u> Last <u>SHIRK</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21, 1871</u>		9. AGE (In years last birthday) <u>90</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Shirk</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Zittle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-9596</u>		INFORMANT Address <u>Mr. Ralph Shirk, 828 Armstrong Ave, Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 448X DUE TO <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelitis, arteriosclerotic disease, generalized</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> , 19____, to <u>death</u> , 19____, that I lost sowed the deceased alive on <u>September 20, 1961</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert F. Keadle</u>		M.D. <u>318 N. Potomac St.</u>				DATE SIGNED <u>9-22-61</u>	
PHYSICIAN'S NAME (Type) <u>Robert F. Keadle</u>		<u>Hagerstown, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 24, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Union Bridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Skiles</u> <u>C.O. Fuss & Son</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 25 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Keadle</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10775

10767

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN <u>MD</u> <u>4 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X MT. AETNA ROAD</u> d. STREET ADDRESS <u>HAGERSTOWN MD. R. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>NINA ELIZABETH SHOEMAICKER</u> First Middle Last				4. DATE OF DEATH <u>SEPTEMBER 7 1961</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>DEC. 1 - 1904</u>		9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>6</u>		10. IF UNDER 24 HRS. Hours <u>7</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>ELLERTON FRED. CO. MD. U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN HARSHMAN</u>				14. MOTHER'S MAIDEN NAME <u>VALLIE HOOVER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>JOHN H. SHOEMAICKER HAGERSTOWN MD. R. 1</u>			
17. INFORMANT <u>JOHN H. SHOEMAICKER HAGERSTOWN MD. R. 1</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <u>465 X</u> IMMEDIATE CAUSE (a) <u>Pulmonary Embolus - R. Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive - Cardiac Vasc. Disease</u> (c) <u>Fatty Liver associated with obesity</u> (d) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Unilateral Hernia - Cholelithiasis & Cholecystitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
20f. (City or town) <u>Hagerstown</u>		20g. (County) <u>Washington</u>		20h. (State) <u>MD</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7 1961</u> to <u>Sept 7 1961</u> that (I) (we) last saw the deceased alive on <u>Sept 7 1961</u> and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Sidney Novenstein</u> M.D.				22b. DATE SIGNED <u>9-8-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>				22d. ADDRESS <u>FUNKSTOWN MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>SEPT. 10 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>			
23d. LOCATION (City, town or county) <u>HAGERSTOWN MD.</u>		23e. (State) <u>MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. East</u>				24a. ADDRESS <u>BOONSBORO MD.</u>			
25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

(M)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 1 week					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 1310 Potomac Ave.					
3. NAME OF DECEASED (Type or print) Elaine Carrington Shunk					4. DATE OF DEATH September 13 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1961		9. AGE (In years last birthday) 5 1 1		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Plainfield, New Jersey		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME George P. Shunk					14. MOTHER'S MAIDEN NAME Margaret A. Hayes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none		17. INFORMANT Address George Shunk, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 902.0 DUE TO Cerebral contusion (b) Atelectasis and lobular pneumonia, left upper and left lower lobes. Atelectasis & hemorrhage, RLL DUE TO (aspiration of vomitus) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 22 hours 11 11		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell from mother's lap.					
20c. TIME OF INJURY Month, Day, Year 7 Hour a.m. 9-12 19 61					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home					20f. (City or town) Hagerstown, Washington, Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE E. W. Ditto, Jr., M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) E. W. Ditto, Jr., M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 9-14-61		22c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		22d. LOCATION (City, town, or country) (State) Rockville, Md.	
23. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown, Md.					ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VS. A15ME
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FOR FILE
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10777

CERTIFICATE OF DEATH

10769

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1019 Corbett St.</u>			d. STREET ADDRESS <u>1019 Corbett St.</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BERTHA MAY SUSAN SHUPP</u>			4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1961</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>November 2, 1883</u>		
9. AGE (in years last birthday) <u>77</u> yrs.			10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Martin V.B. Green</u>			14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>			17. INFORMANT <u>Raleigh A. Shupp</u>		
16. SOCIAL SECURITY NO. <u>None</u>			Address <u>Hagerstown, Maryland</u> <u>1019 Corbett St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>32 days</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15, 1961</u> to <u>Sept 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 15, 1961</u> , and that death occurred at <u>4:38 M</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Frank J. Shupp</u>			22b. DATE <u>9/17/61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Frank J. Shupp</u>			22d. ADDRESS <u>109 1/2 N. Potomac St., Hagerstown, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		23b. DATE THEREOF <u>9/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	
23d. LOCATION (City, town & county) <u>Hagerstown, Maryland</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Maryland</u>			25a. REC'D BY REGISTRAR <u>SEP 21 '61</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>					

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10778

CERTIFICATE OF DEATH

10770

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN It <u>38 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>		d. STREET ADDRESS <u>833 Summit Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Nursing Home</u>							
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Slye</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Shenandoah, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Richard J. Slye</u>				14. MOTHER'S MAIDEN NAME <u>Martha Higgs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-8645</u>		17. INFORMANT <u>Mrs. Maude J. Bell 833 Summit Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis & Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4-20-60</u> <u>9 yrs.</u> <u>years.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> <u>1960</u> to <u>9/3</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>9/3</u> <u>1961</u> , and that death occurred at <u>12:00</u> <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip J. Hirshman</u>				22b. DATE SIGNED <u>9/5/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10779

CERTIFICATE OF DEATH

Reg. Dist. No. 10779

1. PLACE OF DEATH a. COUNTY <i>Washington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1 W. Howard St.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Garlock Nursing Home</i>		d. STREET ADDRESS <i>1 Hagerstown</i>	
3. NAME OF DECEASED (Type or print) First <i>Mande</i> Middle <i>Elizabeth</i> Last <i>Sprinkle</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>17</i> Year <i>19 61</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 10, 1878</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Sprinkle</i>		14. MOTHER'S MAIDEN NAME <i>Amanda Wiley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Rachel Kendle</i>		Address <i>321 Frederick St. Hagerstown, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>332 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <i>Not known</i> <i>Not known</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 16, 1961</i> to <i>Sept. 17, 1961</i> , that I last saw the deceased alive on <i>Sept. 16, 1961</i> , and that death occurred at <i>1:00 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B. B. Kneisley</i>		ADDRESS (Street, city or town, state) <i>148 West Washington St. Hagerstown, Md.</i>	
DATE SIGNED <i>9/18/61</i>			
PHYSICIAN'S NAME (Type) <i>B. B. Kneisley, M.D.</i>		<i>Hagerstown, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/19/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Hagerstown Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rest Haven Funeral Chapel</i>		ADDRESS <i>Hagerstown, Md.</i>	
24a. REC'D BY REGISTRAR <i>SEP 19 1961</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hinds</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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Item 20 Film 297
9-29-61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10780

CERTIFICATE OF DEATH

10772

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in 1b <u>1 MO</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick RD 5</u> d. STREET ADDRESS <u>10x-2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>IDA B. STOTLER</u> First Middle Last				4. DATE OF DEATH <u>SEPT. 18 1961</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1869</u>		9. AGE (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>One Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Cromer</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Duffey</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>D.E. Stotler</u> Address <u>Frederick, Md. RD 5</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>FRACTURE OF RT. HIP</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>6 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injury sustained as result of fall</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>Mar. 1961</u> — p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>In own home</u>		20f. (City or town) <u>Frederick Md.</u> (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9-1-61</u> , 19 <u>61</u> , to <u>9-18</u> , 19 <u>61</u> , that (I) <u>(see)</u> last saw the deceased alive on <u>9-18</u> , 19 <u>61</u> , and that death occurred at <u>5:45</u> P.M., from the causes and on the date stated above.									
22a. SIGNATURE <u>Antonio U. Pallagrosi</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9-18-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLAGROSI</u>				22d. ADDRESS <u>1500 PA AVE HAGERSTOWN MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-21-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resthaven Mem. Garden</u>		23d. LOCATION (City, town or county) (State) <u>Hansonville Fred. Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond C. Brager</u>				ADDRESS <u>Thurmont, Md.</u>		25a. REC'D BY REGISTRAR <u>9-21-61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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CHARLES F. STOUTER

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Handwritten signature

Extensive handwritten notes and signatures, mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10782

CERTIFICATE OF DEATH

10774

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X - RURAL -</u> d. STREET ADDRESS <u>BOONSBORO MD. 171</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>JOHN GEORGE STRAND</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>11</u> Year <u>1961</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 14 - 1891</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>17</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>17</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE PUBLIC SERVICE COM. CRYSTAL FALLS I RON CO. MICHIGAN USA</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>CRYSTAL FALLS I RON CO. MICHIGAN USA</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JOHN STRAND</u>				14. MOTHER'S MAIDEN NAME <u>MARY WIESSLEY</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. LUCY L. STRAND BOONSBORO MD. 171</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>Acute pulmonary edema</u> DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>10 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of pancreas</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>April 1959</u> to <u>Sept. 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 11, 1961</u> , and that death occurred <u>7:30 PM</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Joseph Secondari</u>				22b. DATE SIGNED				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>					
22d. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>SEPT. 14, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baet</u>				24b. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
24c. ADDRESS <u>BOONSBORO MD</u>				DATE <u>SEP 18 '61</u>											



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10783

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1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in 1b 10 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 514 No Mulberry St	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 514 No Mulberry St				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NELLIE Middle MYRTLE Last THOMAS				4. DATE OF DEATH Month Sept Day 20 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 17 1881		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Rocky Ridge Fred Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Smith				14. MOTHER'S MAIDEN NAME Anna Rush			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-13-1900		17. INFORMANT Address Mrs Violet T. Sinn Baltimore 28 Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 18 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1961 to Sept. 20, 1961 that (I) (we) last saw the deceased alive on Sept. 19, 1961 and that death occurred 10A.M. from the causes and on the date stated above.							
22a. SIGNATURE R. A. Bell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-22-61	
22c. PHYSICIAN'S NAME (Type) R. A. Bell, M.D.				22d. ADDRESS 119 N. Potomac St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/23/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR SEP 26 61 DATE	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

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Andrew J. Collins, President

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10784		10776	
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 1 year & 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport d. STREET ADDRESS 1134 W. Potomac St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. John Allison Jice		4. DATE OF DEATH Sept 20 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR 3 Months 7 Days 19 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Western Md. R.R.	
11. BIRTHPLACE (State or foreign country) Williamsport		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Jice		14. MOTHER'S MAIDEN NAME Williamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 09 7345	
17. INFORMANT Mrs. Lelia E. Tice		17a. ADDRESS 134 West Potomac St. Williamsport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 70. Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 1 week			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Sept 20, 1961 Hour a. m. 9:20 p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) (County) (State) Williamsport, Md.			
21. I certify that I (this hospital) attended the deceased from 9/20/61 to 9/20/61 , that I (we) lost saw the deceased alive on 9/20/61 , and that death occurred at 9:20 A. M. from the causes and on the date stated above.			
22a. SIGNATURE Robert L. Young M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9/20/61			
22c. PHYSICIAN'S NAME (Type) Robert L. Young 22d. ADDRESS Williamsport, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Sept. 23, 1961			
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery			
23d. LOCATION (City, town, or county) (State) Williamsport, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Young ADDRESS Williamsport, Md.			
25a. REC'D BY REGISTRAR SEP 21 1961 25b. REGISTRAR'S SIGNATURE Charles S. Hinkle			

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Washington

Western No. 5, B. R.

Alice Wolf

100 West Potomac St.
W. R. Williams, Md.

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Printed and Published by J. M. Williams, 100 West Potomac St., Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10785

CERTIFICATE OF DEATH

10777

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>7 Days</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u> d. STREET ADDRESS <u>50 St Paul Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>COLVIN RUSHMER WADDELL</u>		4. DATE OF DEATH <u>Sept 12 19 61</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18 1907</u>	9. AGE (In years last birthday) <u>53</u> yrs. <div style="display: flex; justify-content: space-between;"> IF UNDER 1 YEAR Months Days </div>	10. KIND OF BUSINESS OR INDUSTRY <u>Linen Serv.</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Toronto, Ont. Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>George Walker Waddell</u>			14. MOTHER'S MAIDEN NAME <u>Kate Cochrane</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes/ Army</u>		16. SOCIAL SECURITY NO. <u>4/8/43-10/11/44 217-12-2043</u>		17. INFORMANT <u>Lauretta F. Waddell</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <div style="display: flex;"> <div style="flex: 1;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute lymphoid leukemia with agnomo-</u> <u>cytosis and septicemia</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) </div> <div style="flex: 1; text-align: right;"> INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <div style="display: flex;"> <div style="flex: 1;"> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> </div> <div style="flex: 1;"> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </div> <div style="flex: 1;"> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) </div> <div style="flex: 1;"> 20f. (City or town) (County) (State) </div> </div>							
21. I certify that (I) (this hospital) attended the deceased from <u>April 1961</u> to <u>Sept 12, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 12</u> 19 , and that death occurred at <u>9:30 A</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John C. Stauffer</u> M.D.			22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) <u>John C. Stauffer M.D.</u>			22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 15/ 61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>			
				23d. LOCATION (City, town or county) (State) <u>Boonsboro Wash. Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Frank Blum Rouser</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Washington

Department

Washington County Hospital

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Lawrence

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State Department

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Washington, D.C.

Very truly yours, Lawrence A. Lawrence

Enclosed are two copies of the
report of the

John C. Lawrence, M.D.

Report of the

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Washington, D.C.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HENRY WASHINGTON WERDEBAUGH				4. DATE OF DEATH Month Day Year SEPT. 28, 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 22, 1905	
9. AGE (In years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 7 Days 8 Hours Min. 		11. BIRTHPLACE (State or foreign country) MORGAN CO. W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM LABORER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MORGAN CO. W.VA.	
13. FATHER'S NAME DAVID W. WERDEBAUGH				14. MOTHER'S MAIDEN NAME LAURA BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 236-50-1261		17. INFORMANT Address MRS FANNIE MAE WERDEBAUGH, RD.1, CLSPG. MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 9/28/61 to 9/28/61 , that (I) (we) last saw the deceased alive on 9/28/61 , and that death occurred at 7 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert F. Young				22b. DATE SIGNED 9/29/61		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 10/2/61		23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEMORIAL GARDENS, HAGERSTOWN, MD.	
23d. LOCATION (City, town, or county) (State)				23e. REC'D BY REGISTRAR 3 '61		23f. REGISTRAR'S SIGNATURE Christina S. Kinn	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Rowland				24b. ADDRESS CLEAR SPRING, MD.			

(M)

10388

STATE OF DEATH

10378

WASHINGTON

WASHINGTON

WASHINGTON COUNTY HOSPITAL

HENRY

WASHINGTON

MALE

AGE 22

FAIR

FAIR

DAVID

DAVID

NO

NO

10/1/51

10/1/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
10787
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Fredrick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R#2 Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waltersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Honewood Church Home</u>		d. STREET ADDRESS <u>10X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>E.</u> Last <u>Wildonger</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24, 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Waltersville</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ezra D. Cramer</u>		14. MOTHER'S MAIDEN NAME <u>Amelia C. Dedrean</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>CSF-328-681211-20-8502</u>	
17. INFORMANT <u>ms Wagner</u>		Address <u>R2, Lonsaft, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> 422 DUE TO <u>Stroke</u> (b) <u>Anterior</u> DUE TO <u>clerum Gen</u> (c) <u>Gen</u>		INTERVAL BETWEEN ONSET AND DEATH <u>min</u> <u>no</u> <u>yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1959</u> to <u>Sept 8, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 1, 1961</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Louis S. Graff</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Louis S. GRAFF</u>		22d. ADDRESS <u>119 E. Antietam St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Fredrick Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. C. Barton, Waltersville, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10788
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 57 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 475 Pangborn Blvd.		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 67 E. Franklin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Lee Wilhide		4. DATE OF DEATH Sept. 14 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 23, 1900
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Dress	11. BIRTHPLACE (County & State, or foreign country) Grimes Va.
12. CITIZEN OF WHAT COUNTRY?		13. MOTHER'S MAIDEN NAME Frances Jane Lamp	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		15. SOCIAL SECURITY NO. 214-09-2582	
16. INFORMANT Paule E. Ausherman		Address Hagerstown, Md	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease with 420.0 DUE TO myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days of failure 2 years of Heart Disease			
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
24. (City or town) (County) (State)			
25. I certify that (I) (the hospital) attended the deceased from 12 Sept 61 to 14 Sept 61 , that (I) (was) last saw the deceased alive on 13 Sept 61 and that death occurred at 230 M , from the causes and on the date stated above.			
26. SIGNATURE F. F. Lusby M.D.			
27. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 28. ADDRESS 230 N Potomac St Hagerstown Md			
29. DATE SIGNED 15 Sept 61			
30. BURIAL, CREMATION, REMOVAL (Specify) Burial			
31. DATE THEREOF 9-16-61			
32. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
33. LOCATION (City, town or county) (State) Hagerstown, Md.			
34. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son			
ADDRESS Hagerstown, Md.			
35. REC'D BY REGISTRAR SEP 19 '61			
36. REGISTRAR'S SIGNATURE Carlton S. Kinn			

10782

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(M)

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

John Henry

John Henry

214-02-2522 Paul E. Washington

(I)

Handwritten notes and signatures, including "John Henry" and "Washington".

X

Large handwritten notes and signatures, including "John Henry" and "Washington".

Scott E. Minnich & Son, Washington, D.C.

Rose Hill Cemetery

Washington, D.C.

Scott E. Minnich & Son, Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10789											
10784											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, and date of admission) e. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 20 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				d. STREET ADDRESS 59 West Side Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 59 West Side Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) VIOLA SENSABAUGH WILSON						4. DATE OF DEATH September 16, 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 4, 1891		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia, Rockbridge Co.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Thomas W. Sensabaugh						14. MOTHER'S MAIDEN NAME Mary S. Benson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service) ---						16. SOCIAL SECURITY NO. None					
17. INFORMANT Mrs. Alice V. Everitts						Address Hagerstown, Maryland, 59 West Side Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive vascular disease DUE TO 44-7X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) general arteriosclerosis and (c) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 5 yr 5 yr											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ① cholelithiasis - ② Secondary anemia (g-I. bleeding)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec 30, 1960 to Sept 16, 1961 , that (I) (we) last saw the deceased alive on Sept 14, 1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Edward W. Ditto III, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/18/61			
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.						22d. ADDRESS 217 West Washington St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/19/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman						ADDRESS Hagerstown, Maryland		25a. REC'D BY REGISTRAR SEP 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Edward V. Davis, M. D.,
The West Washington St. Laboratory, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10782											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.				b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 10 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 1 RFD #1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Raymond Wolfe				4. DATE OF DEATH Month Sept. 15, Day 19 61							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1902		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor				10b. KIND OF BUSINESS OR INDUSTRY farm				11. BIRTHPLACE (County & State, or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert Wolfe				14. MOTHER'S MAIDEN NAME Alice Draper							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.				17. INFORMANT Address A. Richard Wolfe, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 322.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Chronic Alcoholism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 6 Mo. 20 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 9 e.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Smithsburg, Md.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/19 to 9/15 , 19 61 , that (I) (we) last saw the deceased alive on 9/15 , 19 61 , and that death occurred at 7:55 M, from the causes and on the date stated above.											
22a. SIGNATURE Charles F. Hess				22b. DATE SIGNED 9/15/61							
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.				22d. ADDRESS Smithsburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial				23b. DATE THEREOF 9-18-61		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Church		23d. LOCATION (City, town or county) (State) Smithsburg, RFD., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				25a. REC'D BY REGISTRAR SEP 19 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Item 18 Film 295 9-20-61 MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10792 CERTIFICATE OF DEATH 10784											
Item 2 Film G295 9/21/61 iwk											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 Weeks				b. COUNTY Washington			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				d. STREET ADDRESS 202 S. Prospect St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				f. DATE OF DEATH September 12 1961				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALEXANDER MILLER WOODWARD				4. DATE OF DEATH September 12 1961				5. SEX Male			
6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH August 26 1880			
9. AGE (In years last birthday) 81 yrs.				10. IF UNDER 1 YEAR Months Days				11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Dispatcher				10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.				11. BIRTHPLACE (County & State, or foreign country) Roanoke Roanoke Co Va.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Alexander Woodward				14. MOTHER'S MAIDEN NAME Mary Harman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. --- Unable to Locate				17. INFORMANT Katherine W. Richards			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH 21 days				21 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left femur - fell upon hip after suffering Cerebral hemorrhage				21 days				8 yrs.			
(c) Bronchiectasis				8 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 1951				20g. (County) 19				20h. (State) 9/12/61			
21. I certify that (I) (this hospital) attended the deceased from 5: A.M. to 9/12/61, that (I) (we) last saw the deceased alive on 9/12/61, and that death occurred at 5: A.M. from the causes and on the date stated above.											
22a. SIGNATURE S. Earl Young, M.D.				22b. DATE SIGNED 9/12/61				22c. PHYSICIAN'S NAME (Type) S. Earl Young, M.D.			
22d. ADDRESS 148 N. Potomac St., Hagerstown, Md.				22e. ADDRESS 148 N. Potomac St., Hagerstown, Md.				22f. ADDRESS 148 N. Potomac St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/13/61				23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery			
23d. LOCATION (City, town or county) Roanoke Roanoke Co Va				23e. LOCATION (City, town or county) Roanoke Roanoke Co Va				23f. LOCATION (City, town or county) Roanoke Roanoke Co Va			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. ADDRESS Hagerstown Md.				24b. ADDRESS Hagerstown Md.			
24c. ADDRESS Hagerstown Md.				24d. ADDRESS Hagerstown Md.				24e. ADDRESS Hagerstown Md.			
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Andrew A. Goldman & Son, Inc.

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Chas. E. Hall

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

<div>1</div> <div>10793</div> <div>10785</div> <div>03</div>																			
<div>1</div> <div>10793</div> <div>10785</div> <div>03</div>																			
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN TB <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hagerstown General Hosp.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>William</u> <u>Edward</u> <u>Zimmerman</u>			4. DATE OF DEATH <u>September</u> <u>1</u> <u>1961</u>		5. SEX <u>male</u>			6. COLOR OR RACE <u>white</u>											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <u>Sept. 24, 1910</u>		9. AGE (In years last birthday) <u>50</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.							
IF UNDER 1 YEAR	IF UNDER 24 HRS.																		
Months	Days																		
Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel worker</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>												
13. FATHER'S NAME <u>Solomon Zimmerman</u>			14. MOTHER'S MAIDEN NAME <u>Catherine E</u>																
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>W.W.11 213-03-5480</u>		17. INFORMANT <u>Mrs. Gwendel, 6907 Homeway Road, Dundalk, Md</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1"> <tr> <td colspan="5"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull (Temporal Parietal Rt. Extending into Base)</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epidural Hemorrhage, Right</u> (c) <u>Cerebral Contusion Temporal Lobe Bilateral.</u> </td> <td colspan="5"> INTERVAL BETWEEN ONSET AND DEATH <u>Not determined.</u> </td> </tr> </table>										PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull (Temporal Parietal Rt. Extending into Base)</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epidural Hemorrhage, Right</u> (c) <u>Cerebral Contusion Temporal Lobe Bilateral.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Not determined.</u>				
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lying on rt. side at bottom of outside cellar steps.</u>																
20c. TIME OF INJURY Month, Day, Year <u>1</u> <u>8-31-</u> <u>19 61</u>			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> <u>at work</u> <input type="checkbox"/> <u>el work</u> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>40 E. Washington St., Hagerstown, Wash. Md.</u>		20f. (City or town) (County) (State)												
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>[Signature]</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-2-61</u>														
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>			ASSTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			22b. DATE THEREOF <u>9-7-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore</u>												
23. FUNERAL DIRECTOR <u>Wm. Cook-Blight, Inc., 6009 Harford Road</u>					24a. REC'D BY REGISTRAR <u>SEP 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>												

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